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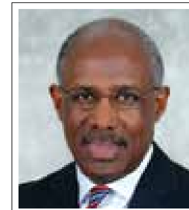
doi: 10.12788/jfp.0189



Systemic racism is a cause of health disparities

I applaud the joint statement by the editors of the family medicine journals to commit to the eradication of systemic racism in medicine (*J Fam Pract*. 2021;70:3-4). These are crucial times in our history, where proactive change is necessary. The leadership they have shown is important.

No one wants health disparities. So, to eliminate them, we need to know what they are and where they came from. In my presentations on health disparities to students, residents, and health care providers, I use 3 definitions of health disparities. My definitions are slightly different from those proposed in the seminal report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* from the National Academy of Medicine (then Institute of Medicine).[1] I like to think that my definitions elicit the information needed to guide change.

The first definition focuses on health statistics. When there are different outcomes for different demographic groups for the same disease, that is a disparity. This could be Black vs white, male vs female, or 1 zip code vs another.[2] We owe ourselves an explanation for these differences if we are to be able to propose solutions.

Second, there are disparities in the provision of health care. If there are 2 individuals who present with the exact same symptoms, we need to ask ourselves why they would be treated differently. Even in systems where insurance status is the same, there are documented differences in care. A well-studied example of this is pain. In 1 such study, a meta-analysis showed that Blacks were less likely than whites to receive medication for acute pain in the emergency department (OR = 0.60 [95% CI, 0.43-0.83]).[3] Other examples of differences by race include cardiac services,[4] lung cancer screening,[5] and stroke interventions.[6]

IMAGE: ©DAVE CUTLER

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The third definition of health disparities involves differences in health-seeking behavior. This is not to blame the "victim," but to understand the reason why the difference exists so that adequate interventions can be designed to improve outcomes. Traditionally, the concept of access referenced whether or

not the patient had health insurance. But the provision of health insurance is insufficient to explain issues of access.[7]

Extrinsic and intrinsic factors at work. Factors related to insurance are an example of the extrinsic factors related to access. However, there are intrinsic factors related to access, most of which involve health literacy. We must ask ourselves: What are the best practices to educate patients to get the care they need? I will take this 1 step further; it is the duty of all health care professionals to improve health literacy 1 patient, 1 community at a time.

The next point that I make in my presentations on health disparities is that if you control for socioeconomic status, some of the health disparities go away. However, they rarely disappear. We measure socioeconomic status in a variety of ways: education, insurance status, income, and wealth. And as would be expected, these variables are usually correlated. We also know that these variables are not distributed equally by race. This is by design. This has been intentional. This has been, in many cases, our country's policy. This is the result of systemic racism.

It is necessary for us to be willing to accept the toxicity of racism. This we can assess in 2 major ways. First, if we apply the Koch postulates or the Bradford Hill criteria for causation to racism, we can assess the degree to which racism is an explanation for health disparities. These principles offer methods for determining the relationship between risk and outcome.

Second, when we analyze the historical antecedents of health disparities, we find that racism is directly responsible not only for the current toxicity that Black people face today, but for the socioeconomic disparities that continue to exist. Let me give just a few examples.

1. **The Farm Security Administration** was created in 1937 to avoid the collapse of the farming industry. As a compromise to southern legislators, a model was approved to allow local administration of support to farmers that essentially condoned the discrimination that had been occurring and would continue to occur—especially in the South.
2. **The National Housing Act of 1934** was created to provide stability to the banking industry at a time of national crisis. It subsidized a massive building program, and many of the units had restrictive covenants that prevented the sale to Blacks. It also codified redlining that prevented insured mortgages from being provided to Black communities.
3. **The Social Security Act of 1935** was created to provide benefits for the elderly and disabled. All workers were included except domestic workers and farm workers—the majority of whom were Black. This was another compromise that was made with southern congressman to get this act passed.
4. **The Servicemen's Readjustment Act of 1944** (also known as the GI Bill) was passed to support veterans returning from World War II. Two major functions of the bill were to support educational opportunities for veterans and their families and to support the purchase of homes. From 1945 to 1954, the US added 13 million new homes. In 1946 and 1947, the Veterans Administration financed 40% of all single-family houses in the United States. Additionally, there were educational benefits for veterans to go to college or to learn a trade. These provisions, education, and housing were not equally available to Blacks. Columbia University professor Ira Katznelson called this act and others "affirmative action for whites."[8]

In 2019, the median income in white households was $76,057 and in Black households it was $46,073.[9] So, when we look at disparities of income, we must acknowledge this difference within the context of the current environment and the historical conditions that created these disparities. If we go 1 step further and look at disparities of wealth, we find that in 2019, the median wealth for white families was $188,200 and the median wealth for Black families was $24,100.[10]

When one considers that a major contributor of wealth is home ownership, these

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differences seem logical—particularly related to points 1, 2, and 4 that I've just described. These economic disparities would not be as great today if the 4 examples given here (not to mention numerous other examples) had been administered equitably. The same applies to disparities in housing, employment, and education. Systemic racism is the causative agent. Systemic racism must be neutralized if we are to obtain anything close to health equity.[11]

The Centers for Disease Control and Prevention (CDC) has recently taken new steps to recognize the role of racism in health.[12] The CDC plans to use "science to investigate and better understand the intersection of racism and health, and then to take action."[13]

It is time for the entire nation to recognize the links between racism and health outcomes and examine how we can design, implement, and evaluate interventions that will permanently correct these inequities. **JFP**

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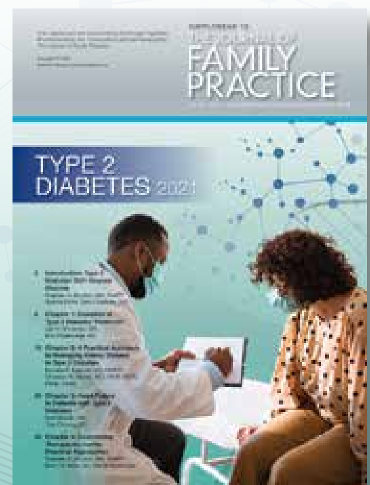
This supplement was sponsored by Boehringer Ingelheim Pharmaceuticals, Inc.
It was edited and peer reviewed by *The Journal of Family Practice*.

Type 2 Diabetes 2021

The management of type 2 diabetes (T2D) has changed substantially over the last several decades. Standard practices have moved away from the glucocentric approach of T2D management into an era in which the interplay among T2D, obesity, atherosclerotic cardiovascular disease, heart failure, and chronic kidney disease is increasingly recognized.

This supplement to *The Journal of Family Practice* brings together key updates in the field of T2D to help physicians care for patients who have not only T2D, but other interrelated diseases.



This supplement can be found at **www.mdedge.com/T2D2021**.